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ABSTRACT

This policy brief begins with a broad overview of what the science of early childhood development tells us about the first three years of life. It then outlines the actions that need to be taken during the reauthorization of the Individuals with Disabilities Education Act (IDEA) to increase the likelihood that policy decisions are guided by state of the art knowledge about early human development and not by ideologically driven advocacy. The following four policy recommendations are discussed: (1) permanently reauthorize Part C of IDEA; (2) provide sufficient funding to identify and serve all infants and toddlers with developmental disabilities or delays; (3) enhance early identification (child find) of infants and toddlers with disabilities; and (4) improve the overall quality of services. A description and brief history of Part C of IDEA is given. Includes 9 references. (Author/SG)

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Improving Part C Early Intervention:

Using What We Know About Infants and Toddlers With Disabilities to Reauthorize Part C of IDEA

February 2003

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Policy Recommendations in Brief

The reauthorization of the Individuals with Disabilities Education Act provides an opportunity to close the gap between what we know and what we do for infants and toddlers with or at risk of disabilities. ZERO TO THREE offers the following recommendations to bring early intervention policy in line with current research findings.

1. Permanently reauthorize Part C.

2. Provide sufficient funding to identify and serve all infants and toddlers with developmental disabilities or delays.

3. Enhance early identification (child find) of infants and toddlers with disabilities.

   a. Require that every infant and toddler who is referred to a protective services agency for evaluation of suspected abuse or neglect be automatically referred for a developmental-behavioral screening under Part C of the Individuals with Disabilities Education Act.

   b. Further strengthen linkages between Part C, Temporary Assistance for Needy Families (TANF), and early care and education systems.

   c. Expand the existing eligibility category of "diagnosed physical or mental conditions" to include "family conditions that have a high probability of resulting in a developmental delay, such as significant parental mental illness, parental substance abuse, and significant family violence."

4. Improve the overall quality of services through the following mechanisms:

   a. Renew investments in professional development with a targeted focus on building expertise in early social-emotional development and mental health, including the creation of a National Resource Center for Infant Mental Health and Early Intervention.

   b. Develop and implement a set of standards for early intervention practice.

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Improving Early Intervention:
Using What We Know About Infants and Toddlers
With Disabilities to Reauthorize Part C of IDEA

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Introduction

The first years of life lay a foundation for the future development of all infants and toddlers. Most babies develop and grow in predictable ways; they walk, talk, and gain new skills on schedule. For some young children, however, development unfolds according to a slower timetable or in an atypical fashion. The primary reason for a problem in early development may be physical, mental, environmental, or a combination of factors. Often the cause remains unknown and the future is uncertain. What we do know, however, is that extremely premature babies, infants with genetic conditions such as Down syndrome, and young children with physical disabilities such as cerebral palsy or spina bifida, among others, need and respond to supportive interventions. Part C of the Individuals with Disabilities Education Act is the federal program that insures that these children and their families are given the best chance for a productive and healthy start.

When eligible children do not receive early intervention services, they and their families, as well as society in general, bear the consequences. For example:

- In the absence of formal intervention, there is a general decline in performance on developmental measures for children with a variety of cognitive disabilities, such as Down syndrome, across the first five years of life (Shonkoff & Phillips, 2000).
- Infants with hearing impairment identified after six months of age had lower language scores than those who were identified prior to six months of age. The developmental disadvantage for the "later identified" group became more pronounced as the children aged; at 3 years of age, the language scores for the "later identified" children were ten months behind those of the children identified before six months of age (Yoshinaga-Itano, Sedy, Coulter, et.al., 1998).
- Infants and toddlers who score in the "at-risk" range of developmental functioning (i.e., below the mean of national norms) and do not receive services frequently move into the lowest functioning at-risk group (i.e., mental retardation) as they get older (Mathematica Policy Research, Inc. & Columbia University's Center for Children and Families at Teacher's College, 2002).

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What is Part C?

Part C authorizes the creation of early intervention programs for infants and toddlers with disabilities, and provides federal assistance for states to maintain and implement statewide systems of services for eligible children, aged birth through two years, and their families. Part C is a discretionary program, which means that states may choose to participate or not. If they do participate, they must fully implement the statutory requirements of the law.

All states and eligible territories are currently participating in the Part C program. Each state receives annual funding under this legislation based on the number of children less than 3 years of age in its population. Under Part C, states and jurisdictions must provide early intervention services to any child below the age of 3 who is experiencing developmental delays or has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. In addition, states may also choose to provide services for infants and toddlers who are "at risk" for serious developmental problems, defined by circumstances (including biological and/or environmental conditions) that will seriously affect the child's development unless interventions are provided. For example, a low birth weight baby who stays in the hospital for 3 months after birth, continues to require supplemental oxygen, is temperamentally difficult to soothe, and has a parent with a substance abuse problem will have a better developmental outcome if the family and child are provided with an individually tailored combination of health, educational, and therapeutic supports. Currently, only eight states include "at-risk children" in their eligible population.

Under the current law, Congress must periodically review and reauthorize Parts C and D (usually every five years) to insure the continuation of their programs and services. Part B, the section of the legislation that authorizes special education and related services for children ages 3 through 21, is authorized permanently.

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What are the benefits of receiving early intervention?

- Children in low-income families who receive early educational intervention starting in infancy have higher scores on mental, reading, and math tests than children who don't receive the intervention and, more importantly, these effects have been shown to persist until at least age 21 (Campbell, Ramey, Pungello, Sparling & Miller-Johnson, 2002).
- Studies of children with autism demonstrate persistent benefits of intensive preschool interventions followed by continuing specialized services throughout the school years (McEachin Smith & Lovaas, 1993).
- Children with severe hearing loss who receive both home-based services and preschool intervention do substantially better than those who receive only center-based services or do not receive any intervention prior to school entry. The effects for reading, arithmetic, vocabulary, speech articulation, percent of the child's communication understood by non-family members, social adjustment, and behavior show that children who receive the most intensive early intervention perform 20-45 percentile points higher than children who do not receive such intervention (White, 1997).

Throughout this paper, the term "early intervention" will be defined as the process of anticipating, identifying, and responding to child and family concerns in order to minimize their potential adverse effects and maximize the healthy development of babies and toddlers. Early intervention services include evaluations of a child's strengths and needs; appropriate educational experiences; special therapies such as physical, occupational, and/or speech and language therapy; family supports such as home visits or parent-to-parent networks; service coordination; and transition supports to facilitate a smooth change from early intervention to preschool programs. These services and supports may be provided in homes, childcare centers, Early Head Start programs, or other early childhood settings.

The re-authorization of IDEA, particularly Part C, provides an opportunity to close the gap between what we know about the benefits of early childhood intervention and what we do for families of infants and toddlers with or at high risk for disabilities. More than four decades of knowledge about early childhood development, which has been integrated into a widely acclaimed report from the National Research Council and Institute of Medicine entitled, *From Neurons to Neighborhoods: The Science of Early Childhood Development*, can help inform the re-authorization process. This meticulously reviewed and authoritative source of cutting-edge research in child development has been used to support the policy recommendations in this document.

This brief begins with a broad overview of what the science of early childhood development tells us about the first three years of life. It then outlines the actions that need to be taken during the re-authorization of IDEA to increase the likelihood that policy decisions are guided by state-of-the-art knowledge about early human development and not by ideologically driven advocacy.

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Brief History of IDEA and Part C

- 1975: Passage of Public Law 94-142, Education for All Handicapped Children Act, which mandated services for children and youth from 3-21 years of age, consistent with state law.

- 1986: Education for the Handicapped Act (EHA) amended by Public Law 99-457 to support states to serve children with disabilities beginning at birth, established Part H, Programs for Infants and Toddlers with Disabilities.

- 1990: EHA further amended by Public Law 101-476, and name changed to Individuals with Disabilities Education Act (IDEA).

- 1997: IDEA re-authorized and sections consolidated so that Part H became Part C.

Currently, IDEA has four parts:

Part A: General Provisions
Part B: Assistance for Education of all Children with Disabilities
Part C: Infants and Toddlers with Disabilities
Part D: National Activities to Improve the Education of Children with Disabilities

The reauthorization of the Individuals with Disabilities Education Act is on the agenda for Congress in 2003. Two sections ----- Part C and Part D ----- were scheduled to expire on September 30, 2002. These sections need to be reauthorized in the 108th Congress.

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What does the science of early childhood tell us about early intervention?

The early years lay an important foundation for later development.
The first three years of life lay an important foundation for the health and development of all children. Infants and toddlers develop competencies in the context of close personal relationships and in their day-to-day interactions with the important people in their lives. What each child experiences during this period of rapid physical and mental growth --- both positive and negative --- will influence how and what he or she learns.

Interactions with caregivers in the first days, months, and years of a child's life shape his or her ability to learn, give and accept love, feel confident and secure, and demonstrate empathy and curiosity ----- all abilities that are central to success in school and later in life. Early intervention that focuses equally on physical, cognitive, social, and emotional development creates a strong framework for growing mastery and independence. *From Neurons to Neighborhoods* states, "The elements of early intervention programs that enhance social and emotional development are just as important as the components that enhance linguistic and cognitive competence" (Shonkoff & Phillips, 2000, p. 11). The science of early childhood tells us that the social and emotional aspects of development for children ----- including children with disabilities ----- are important building blocks for success.

Early intervention can have significant impacts.
Infants and toddlers with disabilities --- which include such conditions as hearing or visual impairment, cerebral palsy, mental retardation, and autism --- benefit from early intervention, as do their families. In such cases, specialized services and supports, such as physical therapy, speech and language therapy, special education, home visits, family support, and service coordination, increase the chances a child will develop to his or her full potential. Young children with special needs who receive early intervention services are better prepared for school and later life. Their families have distinctive needs as well, which Part C addresses by providing both emotional support and information about the child's disability so parents can promote their own child's development and function as his or her best advocate.

The science of early childhood development demonstrates that the most effective interventions are individualized to meet the child's and family's needs, delivered through high-quality programs with well-trained personnel, and provided at a level of sufficient intensity and for a long enough period of time to make a difference. As *From Neurons to Neighborhoods* points out, "Interventions that work are rarely simple, inexpensive, or easy to implement" (Shonkoff & Phillips, 2000, p.10).

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"Model early childhood programs that deliver carefully designed interventions with well-defined objectives and that include well-designed evaluations have been shown to influence the developmental trajectories of children whose life course is threatened by socioeconomic disadvantage, family disruption, and diagnosed disabilities. Programs that combine child-focused educational activities with explicit attention to parent-child interaction patterns and relationship building appear to have the greatest impacts. In contrast, services that are based on generic family support, often without a clear delineation of intervention strategies matched directly to measurable objectives, and that are funded by more modest budgets, appear to be less effective" (Shonkoff & Phillips, 2000, p. 398).

More children can benefit from early intervention.
Since the federal concept of early intervention was created, the number of infants and toddlers receiving services has increased more than six-fold. From 1987 to1988, slightly fewer than 30,000 children with disabilities, age birth through 2 years, were served under IDEA. From 1999 to 2000, that number rose to more than 230,000 (U.S. Department of Education, 2001). Stated simply, the numbers of identified children are increasing dramatically, sometimes beyond the capacity of the systems that serve them. Yet there are still many infants and toddlers with disabilities who are not receiving needed services.

In addition to children with disabilities, infants and toddlers who are at very high risk for significant developmental problems can also benefit from early intervention. These young children do not currently have a diagnosed disability or delay in their development, but their life circumstances result in a high probability for learning difficulties and social problems later in life. This includes infants and toddlers born to parents with drug or alcohol addiction, those whose parents are mentally retarded, or those whose environments contain multiple risk factors such as extreme poverty, family mental health problems, and exposure to violence, abuse, or neglect.

The science of early childhood development asserts that threats to development can originate in the child (i.e., a biological cause for a developmental delay or disability) or in the environment (i.e., adverse circumstances such as family violence, parental mental illness, or substance abuse, which often precipitate developmental difficulties in young children). Significant vulnerability is found more often in circumstances characterized by multiple risk factors rather than one single source. The combined impact of both biological and environmental risk poses the greatest threat. *From Neurons to Neighborhoods* makes the following points:

- The cumulative burden of multiple risk factors and sources of stress compromises the capacity of a caregiver to promote sound health and development. Protective factors and sources of support buffer against potential negative outcomes.
- Children who have experienced physical abuse have lower social competence, show less empathy for others, have difficulty recognizing others' emotions, and are more likely to be insecurely attached to their parents than children who have not experienced abuse. Deficits have also been noted in IQ scores, language ability, and school performance of children who have experienced physical abuse.
- Children with depressed mothers show greater risk of developing socio-emotional and behavior problems, which translate into difficulties in school, poor peer relationships, reduced ability for self-control, and aggression as compared to children with non-depressed mothers.
- Infants and toddlers, whose frontal lobes are experiencing rapid growth, and whose attachment, social-emotional, and regulatory capacities are developing, are particularly vulnerable to the negative effects of maternal depression.
- Children who witness family violence or who are victims of physical abuse directly experience significant consequences such as psychosomatic disorders, anxiety, fears, sleep disruption, excessive crying, and school problems (Shonkoff & Phillips, 2000).

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For children with diagnosed disabilities, early intervention provides intensive supports and services to promote the greatest level of development and independence possible. For children at significant risk, early intervention can serve as a buffer against the multiple factors that hinder their developmental progress. The following recommendations are offered to make our policy in line with our knowledge base.

Family Story

My name is Angel. I was born too early. My mommy stayed healthy while she was pregnant, but still, I was born two whole months before I was due! I was so small, my daddy could hold me in one hand. I stayed in the hospital for two-and-a-half months before I was big enough to come home, and I am still very fragile. I get oxygen through a little tube in my nose, and formula through a tube in my stomach. It is hard for mommy to comfort me; sometimes we both get very frustrated. We can't go out of the house very much because I am so fragile, and there's so much equipment that has to go with me!

While I was in the hospital, a very nice woman came to visit from the local Early Intervention program. She told my mom and dad about the services they could get right in our home. She said that I might need some special therapies to help me walk and talk and learn. My mom and dad could also get help with figuring out the medical bills, and learn soothing ways to hold and sing and talk to me. That nice lady comes to visit us every week now. Sometimes it's hard work for me, but mom and dad are always happy to see her: they can ask her all their questions and she listens. They don't know it yet, but next week, I may stand up for the very first time! Early intervention is working for me.

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Policy Recommendations

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What can policymakers do to assure that more children benefit from early intervention?

The reauthorization of Part C, Programs for Infants and Toddlers with Disabilities, offers an ideal opportunity to connect what we know with what we do for babies and toddlers with disabilities. ZERO TO THREE offers the following recommendations to bring policy more in line with current research findings.

1. Permanently reauthorize Part C.
Part C is an effective mechanism to identify and serve young children with developmental disabilities or delays. Without Part C, infants and toddlers with special needs fall even further behind in their development and consequently require more expensive services and supports later in school and beyond. Without Part C, families would lack the knowledge to cope effectively with the challenges of having a young child with developmental difficulties. Permanent reauthorization would facilitate the integration of early intervention programs into stable, statewide systems of comprehensive services and supports for very young children and their families. Stated simply, if the science of early childhood development points to significant returns from well targeted investments in effective early interventions, why has Part B been permanently authorized while Part C has not?

2. Provide sufficient funding to identify and serve all infants and toddlers with developmental disabilities or delays.
Part C is first and foremost for infants and toddlers with documented disabilities or delays in their development. All children who meet this eligibility criterion must be identified early and appropriately served. A significant percentage of children with disabilities are identified in the first three years of life. Waiting to detect serious learning problems for the first time when children arrive at kindergarten is unacceptable. In the absence of early intervention, such developmental problems often get worse and can lead to secondary disabilities, which will be more expensive to address later. A child with a hearing impairment, for example, may develop serious speech and language delays if he or she is not provided appropriate hearing aids, communication therapy, and special instruction. Unfortunately, there are many infants and toddlers with special developmental needs who would benefit from early intervention but are not identified and served in a timely fashion.

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After the creation of the Early Intervention Program under IDEA, many states considered serving children who are at risk for developmental problems. However, many states feared an influx of large numbers of eligible children and their associated increased costs as well as the potential need for new program approaches and interventions that might have to be developed for this population. Currently, most states are not serving "at-risk" infants and toddlers under Part C. The eight exceptions have adopted a variety of approaches to serving such children[1]. Each of these states has adopted a different set of at risk eligibility criteria (National Early Childhood Technical Assistance Center, 2002). Some states have elected to serve at-risk children only under a particular category of risk (e.g., biological, medical, or environmental risk). Other states consider family circumstances to determine the child's eligibility. Nevada, for example, considers a child at-risk if her or his mother is 15 years old or younger. Massachusetts grants Part C eligibility at birth if a child has at least 4 of 20 potential risk factors. In the absence of a unified approach, or stronger emphasis on prevention, many children are "falling through the cracks."

3. Enhance early identification (child find) of infants and toddlers with disabilities through the following actions:

a. Require that every infant and toddler who is referred to a protective services agency for evaluation of suspected abuse or neglect be automatically referred for a developmental-behavioral screening under Part C of the Individuals with Disabilities Education Act.
b. Further strengthen linkages between Part C, Temporary Assistance for Needy Families (TANF), and early care and education systems.
c. Expand the existing eligibility category of "diagnosed physical or mental conditions" to include "family conditions that have a high probability of resulting in a developmental delay, such as significant parental mental illness, parental substance abuse, and significant family violence."

One of the original tenets of Public Law 99-457, Part H, was that the system of services for young children and families must be interagency in nature. To that end, Part H was characterized as "glue money" and viewed as a mandate for collaboration. Over the years, it has become increasingly clear that while coordinating and streamlining existing service systems is a laudable goal, interagency agreements often fall short of creating systems that are easy to find, easy to use, affordable, and helpful to families of young children with disabilities. In fact, many families have contact with a variety of agencies and professionals in their child's early years, including hospital-based maternity services, pediatricians, health care clinics, child care providers, and family support services, among others. Moreover, the nature of developmental disabilities and the health care delivery system is such that no single agency provides all the necessary services. For example, service coordination may be provided by a public health nurse, while teaching the family how to promote their child's development may be the responsibility of a paraprofessional home visitor. Throughout the nation, early childhood policies, practices, and funding streams remain fragmented, and the time for enhanced coordination is long overdue.

Within this context, one of the most blatant failures in the current service landscape is the missed opportunity to address significant unmet social and emotional health needs in young children who pass through public agencies focused on welfare reform, child protective services, and mental health. *From Neurons to Neighborhoods* points out the following:

- "Early childhood policies and practices are highly fragmented, with complex and confusing points of entry that are particularly problematic for underserved segments of the population and those with special needs. This lack of integrative early childhood infrastructure makes it difficult to advance prevention-oriented initiatives for all children and to coordinate services for those with complex problems" (Shonkoff & Phillips, 2000, p. 399).

[1] States serving at-risk children under Part C include California, Hawaii, Indiana, Massachusetts, New Hampshire, New Mexico, North Carolina, and West Virginia.

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- Multiple federal programs address the problem of child maltreatment, and all states require mandatory reporting of suspected child abuse or neglect, yet large numbers of maltreated young children are managed in child welfare systems that have limited professional expertise in normative child development, developmental disabilities, and early childhood mental health. Both the failure to incorporate state-of-the-art mental health expertise into policies and programs designed to address the needs of children with disabilities and the absence of sophisticated developmental services for young children who have been maltreated are dramatic examples of the significant gap between current knowledge and practice.

From Neurons to Neighborhoods calls for state and local decision-makers to take bold actions to design and implement coordinated, effective infrastructures to reduce the longstanding fragmentation of early childhood policies and programs. For example, each state should be required to develop a systematic plan for developmental screening of all infants and toddlers entering its child welfare system, with a strategy for appropriate referrals of all children with delays or who are at-risk for delays to the Part C system. Specifically, the National Research Council / Institute of Medicine report recommended that states require that all children who are referred to a protective services agency for evaluation of suspected abuse or neglect be automatically referred for a developmental-behavioral screening under Part C of IDEA.

4. Improve the overall quality of services through the following mechanisms:

a. Renew investments in professional development with a targeted focus on building expertise in early social-emotional development and mental health, including creation of a National Resource Center on Infant Mental Health and Early Intervention to enhance the knowledge and skills of personnel who work with infants, toddlers, and their families; and
b. Develop and implement a set of standards for early intervention practice.

The quality of early intervention services is only as good as the individuals who provide them. Therefore, funds should be made available for pre-service and in-service education for the practitioners who are involved in the provision of such services. Substantial new investments should be made to increase the nation's capacity to treat emotional and social problems in young children, including increased funding to train infant mental health specialists. The expansion of opportunities for professional training, as recently called for by the Surgeon General, and the provision of incentives for individuals with pertinent expertise to work in settings with young children, are essential first steps towards more effective screening, early detection, treatment, and ultimate prevention of serious childhood mental health problems.

Standards of Practice

The term "standard" is defined as a statement that defines a goal of practice. Standards carry incentives for universal compliance, but compliance is not necessarily required. Standards have a base of legitimacy or validity derived from scientific or epidemiological data or, when such evidence is lacking, represent the widely agreed upon, state-of-the-art, high-quality level of practice (from http://nrc.uchsc.edu/national/introduc.html).

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As greater numbers of children with a range of developmental and behavioral problems enroll in child care and Early Head Start programs, providers of early care and education are increasingly faced with the limitations of their own professional training and the scarcity of expert consultation available to help them address a variety of special needs. As noted in *From Neurons to Neighborhoods*, "The challenges of establishing relationships with individuals who face varying combinations of child disability and adverse environmental circumstances are substantial. Families with special needs seek guidance in understanding how to promote their child's development and service providers are trained to respect parents' knowledge about their child's unique personal characteristics" (Shonkoff & Phillips, 2000, p. 366).

To address these needs, IDEA Part D (National Activities to Improve Education of Children with Disabilities) should include a priority focus area for infants and toddlers in personnel preparation, training, demonstration, and state improvement grants. Building on high quality practice models that address the unique needs of infants and toddlers, colleges and universities need to support specialized training for practitioners in the infant/family field. The development of innovative models for consultation, supervision, and mentoring, for example, would help program leaders and early intervention providers respond to a variety of societal challenges, such as the shifted emphasis toward natural environments, partnerships with child care and Early Head Start programs, and a renewed focus on school readiness.

Currently, there is no national training vehicle that focuses on infant and toddler practice issues. As a result, their needs take a back seat to those of the larger population of older children and youth. Establishing a National Resource Center for Infant Mental Health and Early Intervention would help by facilitating the sharing of important information and resources among communities and across states.

The need for greater collaboration between mental health systems and early intervention programs is critical. Unfortunately, instruments for evaluating or assessing the social and emotional development of infants and toddlers are not widely available. Personnel trained in this area are scarce, and few states have developed financing or service delivery mechanisms to provide the necessary range of early childhood mental health services. "The limited availability of mental health assistance for children under age 6 represents a massive gap in the current early childhood infrastructure. This shortcoming is particularly problematic in view of the high prevalence of emotional and behavioral problems in young children and the inextricable interrelation among cognitive, social and emotional development" (Shonkoff & Phillips, 2000, p. 372).

The implementation of the original Part H programs for infants and toddlers with disabilities began 15 years ago. Over the ensuing period, state officials who have been responsible for Part C have become increasingly accountable to families, elected state officials, budget managers, auditors, and the federal government. Moreover, although the states have always had to meet federal requirements in order to receive federal early intervention funding, the level of monitoring of state efforts by the U.S. Department of Education has intensified in the last five years with the advent of the Continuous Improvement Monitoring Process. All states now go through a self-assessment process and work towards quality improvement based on this assessment.

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It is clear that the Part C system is committed to meeting federal and state requirements and to improving the quality of its services. One barrier to quality improvement, however, is the lack of nationally recognized standards, measures, benchmarks, or indicators for early intervention programs. Because services are not designed or delivered uniformly, it is difficult to evaluate their impact without such standards. One panel of noted early childhood scientists concluded, " . . . the overarching coherence of the knowledge base that informs the practice of early childhood intervention is compromised significantly by its highly uneven implementation" (National Research Council and Institute of Medicine, 2000, p. 35). Although national standards would not address all implementation concerns, such as access to services, participant attrition, and the overwhelming needs of some families, standards would help to define high-quality practice. In fact, Early Head Start attributes its success to an emphasis on implementing performance standards that ensure high quality services (Mathematica Policy Research, Inc. & Columbia University's Center for Children and Families at Teachers College, 2002). With increased emphasis on quality, accountability, and outcomes-based funding, national standards for early intervention practice would ensure that providers have the information they need to deliver effective, quality services.

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Conclusion

During the first three years of life, an important foundation is created for a lifetime of health and development. These years are even more important for infants and toddlers with special needs. For a young child with a diagnosed disability, early intervention provides intensive services and supports to promote the highest possible level of developmental competence. For children at significant risk, early intervention can serve as a protective buffer against the multiple adverse influences that hinder their developmental progress.

It is clear that children with identified developmental delays or disabilities must remain the priority target group for Part C services. However, it is also clear that multiple risk factors (such as extremely low birth weight, poverty, and exposure to maternal depression, domestic violence, and substance abuse) can derail the early developmental process. If sufficient funding were provided through Part C to promote the development of highly vulnerable infants and toddlers without a diagnosed disability or delay, fewer of these children would exhibit the negative long-term effects of early exposure to environmental and circumstantial risk. Most states, however, have chosen to not serve young children who are at-risk for difficulties, and therefore many such youngsters must wait until a delay or disability appears before Part C services can be offered.

The science of early childhood intervention points to the potential return of significant developmental dividends to young children, their families, and society. Therefore, efforts must focus on permanently authorizing, fully funding, and significantly improving the overall quality of Part C so that the most vulnerable babies and toddlers in our nation have the best possible start in their lives.

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